Home Health Care Fraud and Abuse

Why look at home health care agencies (HHAs)?

- Beneficiaries do not understand Medicare requirements for coverage.

- In the past, beneficiaries did not receive an Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) for home health services, and there was no deductible or co-pay.

Why you may not want to report home health care fraud:

You fear loss of services and even retaliation from the agency, prescribing physician or in-home staff or loss of necessary services.

What is the meaning of 'homebound?"

For beneficiaries to be eligible for home health services, a physician must certify them as being homebound. A beneficiary is homebound if he/she is normally unable to leave home and leaving home requires a considerable and taxing effort. A person may leave for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious services. A need for adult day care does not keep you from getting home health care services.

Fraud schemes:

- **Billing for beneficiaries who are not homebound. Patients are illegally recruited, receive home health care and are NOT homebound.**

- **Unfair marketing practices.** Some HHAs offer incentives to beneficiaries, such as free groceries or free transportation, in exchange for their Medicare number or for switching to their agency.

- **KICKBACKS.** Some HHAs offer cash or other benefits to physicians for referring patients and/or signing treatment plans for patients who do not meet the criteria for home health care.

- Some HHAs have financial ties to durable medical equipment (DME) companies, and their personnel may order supplies that the patients do not need.

- Some HHAs that are licensed by the Arkansas Medicaid program to provide durable medical equipment to eligible Medicaid recipients bill improperly for DME.

  For example, in 2002 the Arkansas Medicaid Fraud Control Unit (MFCU)[1] settled a case against Affordable Home Health Care, Inc. of Paragould for submitting inflated billings for DME to the Arkansas Medicaid Program in excess of the allowable reimbursement rate. The recovered monies, $20,000 in restitution and a fine of $50,000, went into the Arkansas Medicaid Program Trust Fund.[2]

- Some registered nurses provide care to their relatives and bill it as home health care.
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- Billing for more visits or hours than provided.
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- Billing for housekeeping or custodial services as if they were skilled nursing or therapy services.

[1] The federally funded Arkansas law enforcement agency that investigates and prosecutes Medicaid provider fraud and violations of state laws pertaining to fraud in the administration of the Medicaid program. They also review complaints of patient abuse and neglect and of misappropriation of patient funds in all residential healthcare facilities that receive Medicaid funds and, if appropriate, investigate and prosecute the people responsible. The Arkansas MFCU is staffed by attorneys, investigators and auditors trained in the complex litigation aspects of healthcare fraud and patient abuse and neglect.

[2] *The Attorney General reaches settlement in nursing home case,* Little Rock (5/1/02).

- Billing for services not rendered or for care allegedly given to patients who are no longer eligible, who have transferred to another facility, or **who have died – "phantom patients."**

  For example, 20 individuals were convicted for their involvement in a massive and sophisticated scheme to defraud Medicare by the largest certified home health agency in Miami that was paid approximately $120 million in Medicare funds for reimbursement of services, including nursing and home health aide visits. These billed services had either not been provided, were not necessary, or were provided to persons who were not eligible or, in some cases, deceased when the billed services were reportedly rendered. The two highest-level agency administrators admitted to illegal hidden partnerships in hundreds of subcontractor groups and involvement in hundreds of thousands of dollars of illegal payments to numerous individuals from "professional beneficiaries," to home health aides, nurses, and doctors. The convicted defendants received sentences ranging from 18 months imprisonment to, in the case of the highest level administrator, 12 years imprisonment. A single defendant returned $1.1 million in fraudulently obtained assets.[3]

Things to look for:

- Beneficiaries who are not homebound but who are receiving home health services.

- All or most residents in a long-term care facility receive home health care from the same HHA.

- Review Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) to ensure that the services billed match the services that were provided.

- Check your plan of care to see if you are receiving the type and frequency of services ordered by your doctor.

[3] FBI Health Care Fraud Unit, *http://www.fbi.gov/hq/cid/fc/hcf/about/hcf_about.htm*

Be suspicious if a home health provider:

- Tells you to limit your normal activity while receiving home health care so that the homebound condition can be met.
- Pressures you to accept unneeded items or services.
- Tells you the home health aide services are provided to meet your non-health related needs (i.e., shopping, housekeeping and meal preparation).
- Continues to provide home health aide services when you no longer receive or require skilled nursing or therapy services.

It is in your best interest and that of all citizens to report suspected fraud. Health care fraud, whether against Medicare, Medicaid or private insurers, increases everyone's health care costs, much the same as shoplifting increases the costs of the food we eat and the clothes we wear. If we are to maintain and sustain our current health care system, we must work together to reduce costs.

To Report Suspected Medicare or Medicaid Fraud
Call Toll-free 1-866-726-2916
or write to the address below.